CONFIDENTIALITY FORM

WHO REFERRED YOU TO OUR OFFICE?

□ Doctor/Address/phone_____

□ Friend_____

□ Other Source_____

*The **"Texas Oncology- Surgical Oncology office** /has my permission to send correspondence to the following **PHYSICIANS (MD's or D.O.'s only)** concerning my medical information:*

PHYSICIAN'S Full Name Specialty Address Phone

1. _____

2. _____

3._____

*I give my permission allowing "Texas Oncology- Surgical Oncology office @ Baylor Sammons Dallas" to discuss my medical information with the **FOLLOWING INDIVIDUALS:***

Name Relationship Phone

1. _____

2. _____

3._____

I give my permission to contact me via email regarding my medical information.

Email Address: _____

By law we must provide to you a copy of your patient summary for your office visit. Please check below how you would like to receive this information Paper form_____

Internet portal (a pin number will be given for access) _____

May we leave a voice message at the following locations?

Home ☐

Work ☐

Mobile ☐

_____ _____

Patient or Legal Guardian Signature Relationship

_____ _____

Printed Name Date